STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
			B. WIN			02/06/2	2014
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			RAIG ST		
DEDVEU	IRE OF CASTLETO	ON .			APOLIS, IN 46250		
DERNOIT	INE OF CASTLETO	211		INDIAN	AFOLIS, IN 40250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000000							
	This visit was for	or the Investigation of	R00	0000	R000 Initial comments:The		
	Complaint IN00	0142511.			following is the Plan of Correction		
					for Berkshire of Castleton in		
	Complaint IN00	0142511			regards to the Statement of Deficiencies for the complaint		
	•	State deficiencies			survey completed on 2-6-14 T	his	
		llegations are cited at			Plan of Correction is not to be		
					construed as an admission of	or	
	R0214, R0217 and R0240.				agreement with the findings ar		
	0 5 1				conclusions in the Statement of	of	
	Survey Dates:				Deficiencies, or any related		
	February 3 & 6, 2014				sanction or fine. Rather, it is		
					submitted as confirmation of o	ur	
	Facility number	r: 009894			ongoing efforts to comply with		
	Provider number	er: 009894			statutory and regulatory requirements. In this documer	nt	
	AIM number: N	NA			we have outlined specific action		
					in response to identified issues		
	Survey Team:				We have not provided a detaile		
	Mary Jane G. F	Fischer DN			response to each allegation or		
	Mary Jane G. F	-ISCHELKIN			finding, nor have we identified		
	0 1 11				mitigating factors. We remain		
	Census bed type				committed to the delivery of		
	Residential: 13	31			quality health care services an		
	Total: 131				will continue to make changes		
					and improvement to satisfy that objective.	at.	
	Census Payor	type:			asjoonvo.		
	Other: 131						
	Total: 131						
	. 3.6 101						
	Sample: 5						
	Sample. S						
	Those Otata for	diago are sited in					
		idings are cited in					
	accordance wit	th 410 IAC 16.2.					
	Quality Review	was completed by					
	Tammy Alley R	RN on February 10,					
		• ·					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 1 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A BUILDING DO COMPLETED D2/06/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A BUILDING D2/06/2014	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER BERKSHIRE OF CASTLETON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE	AND PLAN OF (F CORRECTION	IDENTIFICATION NUMBER:	A BUILDING	00	COMPLETED
NAME OF PROVIDER OR SUPPLIER BERKSHIRE OF CASTLETON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE						02/06/2014
BERKSHIRE OF CASTLETON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 8480 CRAIG ST INDIANAPOLIS, IN 46250 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE					ADDRESS, CITY, STATE, ZIP CODE	
BERKSHIRE OF CASTLETON (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) INDIANAPOLIS, IN 46250 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE) COMPLETION DATE	NAME OF PRO	OVIDER OR SUPPLIER				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	BERKSHIRE	RE OF CASTLETC	ON			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE						(7/5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	* *					` '
THE RESCRIPTION OF THE PROPERTY OF THE PROPERT					CROSS-REFERENCED TO THE APPROPRIATE	
2014.			LSC IDENTIFFING INFORMATION)	TAG	DE TELEKCT,	DATE
	2	2014.				
R000214 410 IAC 16.2-5-2(a)	R000214 4	410 IAC 16 2-5-2(;	a)			
Evaluation - Deficiency		•				
(a) An evaluation of the individual needs of						
each resident shall be initiated prior to	è	each resident shal	Il be initiated prior to			
admission and shall be updated at least	a	admission and sha	all be updated at least			
semiannually and upon a known substantial	change in the resident 's condition, or more often at the resident 's or facility 's request.					
		A licensed nurse shall evaluate the nursing				
needs of the resident.	1				 B 044	
Based on record review and R000214 R 214 Evaluation 03/05/2014				R000214		03/05/2014
interview the facility failed to ensure (deficiency)What corrective action(s) will be accomplished for	ir	interview the fa	cility failed to ensure			for
an evaluation was updated when those residents found to have	а	an evaluation w	vas updated when		, ,	101
there was a change in the resident's been affected by the alleged	tr	there was a cha	ange in the resident's			
condition, in that when a resident deficient practice?Resident A:			•			
was identified with the need of Personal Service plan,		•			·	
assistance and supervision while assignment sheet and care					•	
assistance and supervision wille profiles have been undated to			•			
bathing, the nursing staff failed to include the level of supervision		~	•			
provide the required supervision. and care required for this resident	1 -		-		l ·	
The resident fell from a shower chair during ADL care. Terrace Nurse						se
and sustained a fractured hip. This will supervise care needs of	a	and sustained a	a fractured hip. This			_
deficient practice effected 1 of 3 residents and update the plans based on changes of condition or	d	deficient practio	ce effected 1 of 3			
residents reviewed for falls in a additional service requests, in an	l re	residents review	wed for falls in a		_	
sample of 5. (Resident "A"). ongoing manner. How will the					•	
facility identify other residents					• •	
Findings include: with the potential to be affected	_	Findings include	۵.			d
by the same alleged deficient		i indings includ	C.		•	
practice and what corrective	_	The	Danidant HAH			
The record for Resident "A" was action will be taken? Other						
reviewed on 02-03-2014 at 10:30 residents who live on the Terrace						
a.m. Diagnoses included, but were have the potential to be affected	a	a.m. Diagnose	es included, but were			
not limited to, Stage three renal by the alleged deficient practice.	n	not limited to, S	Stage three renal		by the alleged deficient practic	ce.

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
			A. BUILDING B. WING		02/06/2014	
		l	_	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		CRAIG ST		
BEDKCH	IIRE OF CASTLET	N.		ANAPOLIS, IN 46250		
				147.1 OLIO, IIV 70200		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE	
failure, Myasthenia Gravis, left				The Terrace Nurse/Designee		
	hemiparesis, g	laucoma,		completed a 100% audit of all Personal Service Plans,		
	hypertension, of	cerebral vascular		assignment sheets and care		
	accident and d	ementia. These		profiles on the unit to ensure t	he	
	diagnoses rem	ained current at the		needs of the resident are		
	time of the rec			accurately reflected on these		
				documents. This audit include		
	The resident's	nre-admission		interviews with residents as w	ell	
		ated 01-15-2003		as caregivers, with particular	,	
	· · · · · · · · · · · · · · · · · · ·			attention to personal care and		
	indicated the resident had a history			assistance with activities of da living, based on individual nee		
	of fractures - status post fracture of			and preferences. Updates wi		
	the hip with open reduction and			made in an ongoing manner a		
		n (2001), falls and left		the needs or preferences of the		
	sided weaknes	ss. This		resident change.		
	pre-admission	assessment indicated		What measures will be put in		
	the resident us	ed a "shower chair,"		place or what systemic chang		
		endent with bathing		will the facility make to ensure		
	and showering	•		alleged deficient practice does		
	_	nd care plan," dated		not recur?Nurses and caregiv will be re-educated on the cha		
		dicated the resident		of condition policy. This traini		
				will be provided by the Health		
		in past 3 months,		Wellness Director/Designee,		
		nt, adequate vision		will include training on the		
		oroblems with balance		requirement of supervision of	the	
		, walking decreased		care associates by nurses, as		
	coordination, a	ind was jerky or		well as the need for the	:	
	unstable when	making turns." The		caregivers to notify the nurse the event a resident is	in	
	"total score" fo	r this assessment was		non-compliant with supervisio	n or	
	21. The asses	sment indicated a		is using their resident right to		
	score of 10 or	above identified the		refuse supervision or		
		igh risk for falls.		assistance.Nurses will be		
				instructed to document all		
	A rovious of the	e "Personal Service		refusals of care in the clinical		
				record, as well as to record su		
		1-26-12, indicated the		events in the 24 hour shift-to-		
		neurodegenerative		log, so that the supervisor will		
	disease which	"may impact a		alerted to the change in reside	ent	

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 3 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WING			02/06/2	2014
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L.			RAIG ST		
BERKSH	IRE OF CASTLETO	N			APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
resident's activities of daily living.					status or care needs. How wil	I	
	Refer to the oth	ner sections of the			the corrective actions be	.	
	Service Plan fo	or further direction.			monitored to ensure the deficie		
	MYASTHENIA	GRAVIS. Showering			practice will not recur, i.e., who quality assurance programs w		
		esident does not			be put in place? The 24 h		
	_	ing and bathing			shift-to-shift report log will be		
	assistance."	ing and bading			reviewed by the Terrace Nurse	e	
	นออเอเสทิเษ				daily and adjustments to the		
	On 02 02 2044	at 1:45 p.m., the			Personal Service Plan,		
		•			assignment sheet or resident	.	
	facility provided	•			Care Profile will occur, based observations and the contents		
	Therapy and Physical Therapy "visit				the clinical record. The Terrac	-	
	note" reports, that were not a part				Nurse/Health and Wellness		
		ecord. The reports			Nurse and/or Executive Direct	or	
	indicated the fo	ollowing:			will then schedule care		
					conferences with the responsi		
	"01-09-13 [201	3] DC [discharge] of			party for each resident affecte		
	OT [occupation	nal therapy] services,			in order to review any change		
		esident was alert and			care needs, or changes in cos associated with the change of		
	oriented and "ir	ntact intellectual			condition. Such services will		
		urther review of this			include, but will not be limited	to	
	_	cated the following:			changes in scope, frequency,		
		to wash entire body			needs, and/or preferences of t	:he	
	•	•			resident. The agreed-upon		
		s grooming (washing			Personal Service Plan will be		
	face, washing h				signed and dated by the resident/responsible party and		
		air). Note If the tub or			copy of the Personal Service F		
		fe, select either "4" or			shall be given to the resident	ian	
	"5" at minimum				upon request. The community	,	
		tient restricted from			will continue to utilize the		
	stair climbing a	nd the only			Collaborative Care Meeting		
	tub/shower ava	ilable requires it.			process twice monthly to		
	Able to particip	ate in bathing self in			encourage improved		
		but requires presence			communication between third party providers and the		
		on throughout the			healthcare associates. These		
	•	ince or supervision."			meetings will be multi-discipling		
		and or dupor violon.			in nature and each resident wi	-	

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 4 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 02/06 /	ETED	
			B. WIN			02/06/	ZU 1 4
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					RAIG ST		
BERKSH	IRE OF CASTLETO	JN 		INDIAN.	APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	4-	TAG	DEFICIENCY)		DATE
	"01-11-13 DC (., ,			be reviewed for changes in		
	therapy] service				condition, changes in risk fact including, but not limited to: fa		
	INTERRATOR	- Unable to			weight changes, nutritional	113,	
	participate effe	ctively, dependent in			concerns, or other pertinent		
	bathing and is	bathed totally by			information, which will then be		
	another person	1."			incorporated into the Persona		
					Service Plan, Assignment Pla and /or the Care Profile for ea		
	In addition, the	record indicated the			resident. By what date will the		
	resident had ar	n Occupational			systemic changes be		
	Therapy evaluation conducted on				implemented?3-5-14		
	02-08-2013. The evaluation						
	indicated the resident required						
	maximum assistance with bathing						
		maximum assistance					
	· ·	e upper and lower					
	_	luation also indicated					
	the need for a '						
		view on 02-03-14 at					
		Director of Nurses					
	indicated the e						
		he use of wheelchair					
		I not the resident					
	needs for bathi						
		···a·					
	A subsequent a	evaluation, dated					
	05-13-13 and r						
		OT (occupational					
	`	es, indicated the					
		npaired decision					
		to perform usual					
		s of daily living] or					
		, 0.					
	inability to appr						
		ardizes safely <sic></sic>					
	through actions	5 .					

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/06/2014	
	PROVIDER OR SUPPLIE		8480 C	ADDRESS, CITY, STATE, ZIP CODE RAIG ST IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		e Interdisciplinary s indicated the			
	CNA [certified said she rolled	:45 a.m. Res. nd sitting on floor by nurses aide]. Res. over and slid out of nees, denies pain no			
	room by CNA. is sitting [illegil floor. Head to completed - re	p.m. Nurse called to Writer observed res. ole word] on shower toe assessment s. without injury. Res. se of call light for			
	calling out. Er [apartment], fo B.R. [bathroon	und res. sitting on n] floor in front of nied falling, denies			
	resident yell for [and] CNA ent [and] observed on her right his allow writer or floor. Writer as move her right	o p.m. Writer heard r 'help.' Writer et ered resident room et d res. on shower floor o. Resident would not CNA to assist from sked if res. could leg, res. said 'no.' es, 'how did you fall ?'			

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 6 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPI	E CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
			B. WING			02/06/	2014
		<u> </u>	_	ЕЕТ А	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	₹			RAIG ST		
BERKSH	IRE OF CASTLETO	NC			APOLIS, IN 46250		
				- 1			(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES	ID	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	_	BELLEER		DATE
	Res. said 'I wa	•					
something.' Res. said 'I'm hurting."							
	Further review	of the					
	Interdisciplinar	y notes indicated the					
	resident was tr	ansferred to the local					
	area hospital fo	or evaluation and					
	treatment and subsequently						
		a fractured hip. After					
the resident's hospitalization, the							
resident was transferred to a skilled							
	nursing facility for rehabilitation						
	services.						
	A	facility UDials					
	A review of the	•					
		valuation, dated					
		ated the resident had					
	•	ast 12 months, with a					
	left hip fracture	e [09-07-13], a vision					
	deficit of glauce	oma, with "factors					
	observed that i	may cause the					
		- Myasthenia Gravis					
		ft hemiparesis."					
	[22:2:3] 53						
	A review of the	facility Incident					
		03-14 at 11:00 a.m.,					
	-	07-13 at 7:35 p.m.,					
		•					
		ncident occurred on					
	•	e resident "bathroom,					
		Nature of Incident:					
	•	ed. Severity Code					
		with admission to					
	hospital."						
	During an inter	view on 02-03-14 at					
	_						l

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 7 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMI	E SURVEY PLETED 6/2014	
	PROVIDER OR SUPPLIEF		8480 CI	ADDRESS, CITY, STATE, ZIP C RAIG ST APOLIS, IN 46250	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	"The screw car chair - that's ho broke my hip. hollered until some." When intwas with her in she was in the indicated, "No myself but I ho them to hear mattended in the current of the current 12-07-13 indicated to perform showering tasks."	esident fell while left the shower, a review Care Profile," dated ated the "resident is a the following as with physical heeded: washing er body."				

State Form Event ID: 9P6611 Facility ID: 009894 If continuation sheet Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
					02/06/2014
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
DEDIKOLI	IDE OF OAOT! ETC			RAIG ST	
BERKSH	IRE OF CASTLETC)N	INDIAN	APOLIS, IN 46250	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
R000217	410 IAC 16.2-5-2(e)(1-5)			
	Evaluation - Defici				
		pletion of an evaluation,			
	the facility, using a	appropriately trained staff			
	members, shall ide	entify and document the			
	services to be prov	vided by the facility, as			
	follows:				
		ffered to the individual			
	resident shall be a	ppropriate to the:			
	(A) scope;				
	(B) frequency;				
(C) need; and (D) preference; of the resident.					
(2) The services offered shall be reviewed					
	and revised as appropriate and discussed by				
	•	acility as needs or desires			
		e facility or the resident			
	may request a ser				
		on service plan shall be			
		by the resident, and a			
	copy of the service	e plan shall be given to the			
	resident upon requ	uest.			
	(4) No identificatio	n and documentation of			
	•	is needed if evaluations			
	•	initial evaluation indicate			
	no need for a char				
	` '	n of medications or the			
	•	ential nursing services, or			
		licensed nurse shall be			
		cation and documentation			
	of the services to b	•	D000017	R 217 Evaluation	02/05/2014
	Based on recor		R000217	(deficiency)What corrective	03/05/2014
		cility failed to ensure		action(s) will be accomplished	for
	that after an ev	aluation was		those residents found to have	
	completed by the	he therapy staff, the		been affected by the alleged	
	facility failed to			deficient practice?Resident A:	
	appropriate services required for the resident in regard to the need of			Personal Service plan,	
				assignment sheet and care	
				profiles have been updated to	
	supervision wh	ile bathing/showering		include the level of supervision	ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			A. BUII B. WIN			02/06/	2014
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RAIG ST		
DEDKCH	IRE OF CASTLETO	ΩN.			APOLIS, IN 46250		
DERNOI	IIRE OF CASTLETO	3N		INDIAN	AFOLIS, IN 40250		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for 1 of 3 reside	ent's reviewed for falls			and care required for this resid		
	in a sample of	5. (Resident "A").			during ADL care. Terrace Nur	se	
					will supervise care needs of residents and update the plans		
	Findings includ	le:			based on changes of condition		
					additional service requests, in		
	The record for	Resident "A" was			ongoing manner. How will the		
		2-03-2014 at 10:30			facility identify other residents		
					with the potential to be affected	d	
	a.m. Diagnoses included, but were				by the same alleged deficient		
	not limited to, Stage three renal				practice and what corrective action will be taken? Other		
	failure, Myasthenia Gravis, left				residents who live on the Terra	200	
	hemiparesis, glaucoma,				have the potential to be affected		
	hypertension, cerebral vascular				by the alleged deficient practic		
	accident and dementia. These				The Terrace Nurse/Designee I		
	diagnoses rem	ained current at the			completed a 100% audit of all		
	time of the reco	ord review.			Personal Service Plans,		
					assignment sheets and care		
	The resident's	pre-admission			profiles on the unit to ensure the	ne	
	assessment, d	ated 01-15-2003			needs of the resident are accurately reflected on these		
		esident had a history			documents. This audit include	ed	
		tatus post fracture of			interviews with residents as we		
		en reduction and			as caregivers, with particular		
		n (2001), falls and left			attention to personal care and		
	sided weaknes	•			assistance with activities of da	-	
					living, based on individual nee	_	
	l -	assessment indicated			and preferences. Updates will		
		ed a "shower chair,"			made in an ongoing manner at the needs or preferences of th		
		endent with bathing			resident change.	Č	
	and showering				What measures will be put in		
		nd care plan," dated			place or what systemic change	es	
	01-15-2003 inc	licated the resident			will the facility make to ensure		
	had "1 - 2 falls	in past 3 months,			alleged deficient practice does		
	was incontinent, adequate vision				not recur?Nurses and caregive		
	with glasses, p	roblems with balance			will be re-educated on the cha of condition policy. This training	•	
		, walking decreased			will be provided by the Health	-	
		nd was jerky or			Wellness Director/Designee, a		
		making turns." The			will include training on the		
	I andiable wilen	making tarris. The	1		l		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WIN			02/06/2014	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER	L			RAIG ST		
DEDICH	IRE OF CASTLETO	NI.					
DERNOH	IKE OF CASILETO	JN .		INDIAN	APOLIS, IN 46250		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	"total score" for	this assessment was			requirement of supervision of	the	
	21 The asses	sment indicated a			care associates by nurses, as		
		above identified the			well as the need for the		
					caregivers to notify the nurse	in	
	resident as a n	igh risk for falls.			the event a resident is		
					non-compliant with supervision	n or	
	A review of the	"Personal Service			is using their resident right to		
	Plan," dated 11	-26-12, indicated the			refuse supervision or		
		neurodegenerative			assistance.Nurses will be		
	disease which	_			instructed to document all		
					refusals of care in the clinical	1-	
resident's activities of daily living.					record, as well as to record su		
Refer to the other sections of the					events in the 24 hour shift-to-s		
Service Plan for further direction.					log, so that the supervisor will		
	MYASTHENIA	GRAVIS. Showering			alerted to the change in reside status or care needs. How will		
		sident does not			corrective actions be monitore		
	_	ing and bathing			ensure the deficient practice v		
	•	ing and bathing			not recur, i.e., what quality	VIII	
	assistance."				assurance programs will be pu	ıt in	
					place? The 24 hour		
	The record indi	cated the resident			shift-to-shift report log will be		
	had an Occupa	itional Therapy			reviewed by the Terrace Nurs	e	
	evaluation cond				daily and adjustments to the		
	02-08-2013. T				Personal Service Plan,		
					assignment sheet or resident		
		esident required			Care Profile will occur, based		
		stance with bathing			observations and the contents	of	
	transfers, and r	maximum assistance			the clinical record. The Terrac	e	
	with bathing the	e upper and lower			Nurse/Health and Wellness		
	body. The eva	luation also indicated			Nurse and/or Executive Direct	or	
	the need for a '				will then schedule care		
		c			conferences with the responsi		
	A ouboomist	avaluation datad			party for each resident affecte		
		evaluation, dated			in order to review any change		
	05-13-13 and n				care needs, or changes in cos		
	(discharge) of (OT (occupational			associated with the change of condition. Such services will		
	therapy) service	es, indicated the			include, but will not be limited	to	
		npaired decision			changes in scope, frequency,	10	
		to perform usual			needs, and/or preferences of t	the	
	_	•			resident. The agreed-upon	u ic	
	ADLS [activities	s of daily living] or			Testachi. The agreeu-upoil		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
			A. BUILDING B. WING		02/06/2014	
	•		_	Γ ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		CRAIG ST		
BERKSH	IIRE OF CASTLETO	NC		NAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	inability to appropriately stop			Personal Service Plan will be		
	activities, jeopa	ardizes safely <sic></sic>		signed and dated by the		
	through actions			resident/responsible party and		
				copy of the Personal Service I shall be given to the resident	Pian	
	A review of the Interdisciplinary			upon request. The community	,	
	Progress Notes	·		will continue to utilize the	,	
	following:			Collaborative Care Meeting		
		p.m. Nurse called to		process twice monthly to		
				encourage improved		
	•	Writer observed res.		communication between third		
	is sitting [illegible word] on shower			party providers and the healthcare associates. These		
	floor. Head to toe assessment			meetings will be multi-discipling		
	completed - res. without injury. Res.			in nature and each resident w		
		se of call light for		be reviewed for changes in		
	assistance."			condition, changes in risk fact	 	
				including, but not limited to: fa	lls,	
	"07-27-13 5:00	a.m. Heard res.		weight changes, nutritional		
	calling out. En	tered apt.		concerns, or other pertinent information, which will then be	,	
	[apartment], fo	und res. sitting on		incorporated into the Persona		
	B.R. [bathroom	n] floor in front of		Service Plan, Assignment Pla		
	_	ied following, denies		and /or the Care Profile for ea		
	pain. No injuri	•		resident. By what date will the	se	
				systemic changes be		
	"09-07-13 7·35	p.m. Writer heard		implemented?3-5-14		
		r 'help.' Writer et				
		ered resident room et				
		I res. on shower floor				
		o. Resident would not				
		CNA to assist from				
		sked if res. could				
		leg, res. said 'no.'				
		es. 'how did you fall ?'				
	Res. said 'I wa	•				
	something.' Re	es. said 'I'm hurting.'"				
	Eusthon soulisie	of the				
	Further review	oi the		<u> </u>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	00	COMPL	ETED
			B. WING			02/06/	2014
		<u> </u>		TREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF P	PROVIDER OR SUPPLIEF	₹			RAIG ST		
	IRE OF CASTLETO			NDIAN	APOLIS, IN 46250		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA			TE	COMPLETION
TAG		<u> </u>	1	AG	DEPTCIENCT)		DATE
	•	y notes indicated the					
		ansferred to the local					
	•	or evaluation and					
	treatment and						
		a fractured hip. After					
		nospitalization, the					
		ansferred to a skilled					
	nursing facility	for rehabilitation					
	services.						
	A review of the	facility Incident					
	Report on 02-0	03-14 at 11:00 a.m.,					
	and dated 09-0)7-13 at 7:35 p.m.,					
	indicated the ir	ncident occurred on					
	Saturday in the	e resident "bathroom,					
	_	Nature of Incident:					
		ed. Severity Code					
		with admission to					
	hospital."						
	A review of the	facility "Risk					
		valuation, dated					
		ated the resident had					
		ast 12 months, with a					
		e [09-07-13], a vision					
	•	oma, with "factors					
	_						
	observed that i	•					
	resident to fall - Myasthenia Gravis						
	i įseverėj and lė I	ft hemiparesis."					
	During an inter	view on 02-03-14 at					
	_						
	•	resident indicated					
		me out of the shower					
		ow I fell - that's when I					
	broke my hip.	I laid on the floor and					

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8480 C	ADDRESS, CITY, STATE, ZIP CODE RAIG ST IAPOLIS, IN 46250 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS.REFERENCED TO THE APPROPRIAT	(X5)
PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	(X5)
	DEFICIENCY)	COMPLETION
R000240	R 240 (deficiency)What correct	ive 03/05/2014
	R000240	PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATI

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED				
			B. WING		02/06/201	14		
	NAME OF PROVIDER OR SUPPLIER BERKSHIRE OF CASTLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250				
	SUMMARY S' (EACH DEFICIEN REGULATORY OR interview the fa specific care ar assistance to a when a resider the need of ass supervision wh nursing staff fa required care a 3 resident's rev identified with r care and servic on the Terrace The lack of car assistance resi resident, which fractured hip. (Findings includ During an inter 8:45 a.m., the A indicated that a	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Icility failed to provide and personal resident, in that at was identified with sistance and ile bathing, the iled to provide the and assistance for 1 of viewed who were needing additional ces and also resided Unit. e and personal alted in a fall by a resulted in a (Resident "A"). e:	STREET 8480 C	CRAIG ST	plished for to have attended to pervision and the plans and the plans affected affected affected affected at practice, signee has at acre.	(XS) OMPLETION DATE		
	facility did have where resident with the need of	e a unit (The Terrace) s who were identified of extra assistance		needs of the resident a accurately reflected on documents. This audit interviews with residen	these included ts as well			
	The Manor, do residents who is assistance as if The resident's on the Terrace additional assistance.	required additional t is Assisted Living. who currently resided Unit required stance and		as caregivers, with par attention to personal ca assistance with activitie living, based on individ and preferences. Upda made in an ongoing made in an ongoing made in an ongoing made in eneeds or preference will be	are and es of daily ual needs ates will be anner as es of the			
	•	e eating and toileting. staff over there."		What measures will be place or what systemic	•			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
			A. BUIL B. WING			02/06/	2014
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	₹					
BEDREH	IRE OF CASTLETO	ΩNI			RAIG ST APOLIS, IN 46250		
	INE OF CASILET			INDIAN	AI OLIO, IIN 40200		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					will the facility make to ensure		
	The record for	Resident "A" was			alleged deficient practice does		
	reviewed on 02	2-03-2014 at 10:30			not recur?Nurses and caregive will be re-educated on the cha		
	a.m. Diagnose	es included, but were			of condition policy. This training	•	
	_	Stage three renal			will be provided by the Health	-	
		enia Gravis, left			Wellness Director/Designee,		
	hemiparesis, g				will include training on the		
		cerebral vascular			requirement of supervision of	the	
		ementia. These			care associates by nurses, as		
					well as the need for the	_	
	_	ained current at the			caregivers to notify the nurse in the event a resident is	rı	
	time of the reco	ora review.			non-compliant with supervision	n or	
					is using their resident right to	1 01	
	The resident's	pre-admission			refuse supervision or		
	assessment, d	ated 01-15-2003			assistance.Nurses will be		
	indicated the re	esident had a history			instructed to document all		
		tatus post fracture of			refusals of care in the clinical		
		en reduction and			record, as well as to record su		
	· ·	n (2001), falls and left			events in the 24 hour shift-to-s		
	sided weaknes				log, so that the supervisor will alerted to the change in reside		
		assessment indicated			status or care needs. How will		
	· •				corrective actions be monitore		
		ed a "shower chair,"			ensure the deficient practice w		
	•	endent with bathing			not recur, i.e., what quality		
	and showering				assurance programs will be pu	ut in	
		nd care plan," dated			place? The 24 hour		
	01-15-2003 inc	licated the resident			shift-to-shift report log will be		
	had "1 - 2 falls	in past 3 months,			reviewed by the Terrace Nurse	ŧ	
	was incontinen	it, adequate vision			daily and adjustments to the Personal Service Plan,		
	with glasses, p	roblems with balance			assignment sheet or resident		
		, walking decreased			Care Profile will occur, based	on	
	coordination, and was jerky or unstable when making turns." The				observations and the contents		
					the clinical record. The Terrac	е	
		r this assessment was			Nurse/Health and Wellness		
		sment indicated a			Nurse and/or Executive Direct	or	
					will then schedule care	blo	
		above identified the			conferences with the responsi		
	resident as a h	igh risk for falls.			party for each resident affecte	u,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			LETED
			B. WING		02/06	6/2014
NAME OF I	PROVIDER OR SUPPLIER	· }	STREET	ADDRESS, CITY, STATE, ZIP COD	Е	
TWINE OF F	NO VIDER OR SUITEEF	·		RAIG ST		
BERKSH	IRE OF CASTLETO	ON	INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
IAU	A review of the Plan," dated 11 resident had a disease which resident's active Refer to the oth Service Plan for MYASTHENIA or Bathing - Refer to the oth Service Plan for MYASTHENIA or Bathing - Refer to the oth Service Plan for MYASTHENIA or Bathing - Refer to the other assistance." On 02-03-2014 facility provided Therapy and Protein reports, to the resident's reindicated the form of the resident's reindicated the reference oriented and "infunctioning." From the evaluation indicated the resident and "in	"Personal Service 1-26-12, indicated the neurodegenerative "may impact a ities of daily living. ner sections of the or further direction. GRAVIS. Showering esident does not ring and bathing Lat 1:45 p.m., the d Occupational hysical Therapy "visit hat were not a part ecord. The reports ollowing: 3] DC [discharge] of nal therapy] services, esident was alert and intact intellectual further review of this cated the following: to wash entire body as grooming (washing hands and air). Note If the tub or offe, select either "4" or in. "4" - "6" are officient restricted from	IAU	in order to review any checare needs, or changes in associated with the change condition. Such services include, but will not be limed changes in scope, freque needs, and/or preference resident. The agreed-upon Personal Service Plan will signed and dated by the resident/responsible party copy of the Personal Service plan will signed and dated by the resident/responsible party copy of the Personal Service plan will be given to the residupon request. The commic continue to utilize the Collaborative Care Meeting process twice monthly to encourage improved communication between the party providers and the healthcare associates. The meetings will be multi-disting in nature and each reside be reviewed for changes condition, changes in risk including, but not limited the weight changes, nutritional concerns, or other pertines information, which will the incorporated into the Pers Service Plan, Assignment and /or the Care Profile for resident. By what date will systemic changes be implemented?3-5-14	anges in no cost ge of will nited to ncy, sof the in libe y and a vice Plan dent unity will ng third hese ciplinary ent will in a factors, to: falls, all ent en be sonal t Plan or each	DAIL
	stair climbing a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			02/06/	2014
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R					
BERKSH	IRE OF CASTLETO	ON	8480 CRAIG ST INDIANAPOLIS, IN 46250				
,			1		711 0210, 114 10200		Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)		ΓE	DATE			
ing		<u> </u>	1	1710	<u> </u>		DATE
	·	ate in bathing self in					
	shower or tub, but requires presence of another person throughout the bath for assistance or supervision."						
	"01-11-13 DC (·					
	therapy] servic						
	INTERRATOR						
		ctively, dependent in					
	bathing and is bathed totally by another person,"						
	In addition the	record indicated the					
	resident had ar	n Occupational					
		ation conducted on					
	02-08-2013. T						
		esident required					
		stance with bathing					
		•					
	· ·	maximum assistance					
	_	e upper and lower					
		luation also indicated					
	the need for a	"shower chair."					
	•	evaluation, dated					
	05-13-13 and r	noted as a DC					
	(discharge) of	OT (occupational					
	therapy) servic	es, indicated the					
	resident had "ir	mpaired decision					
		to perform usual					
	ADLS [activities of daily living] or inability to appropriately stop activities, jeopardizes safely <sic></sic>						
	through actions	•					
	unough actions	J.					
	During an inter	view on 02-03-14 at					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		02/06/2014
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIE	R		CRAIG ST	
	IRE OF CASTLETO		INDIAN	NAPOLIS, IN 46250	
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		,	TAG	DEFICIENCY)	DATE
	_ ·	Director of Nurses			
	indicated the evaluation was				
		the use of wheelchair			
		d not the resident			
	needs for bath	ing.			
		e Interdisciplinary			
	Progress Note	s indicated the			
	following:				
	"07-14-13 8:00	p.m. Nurse called to			
	room by CNA.	Writer observed res.			
	is sitting [illegit	ole word] on shower			
	floor. Head to	toe assessment			
	completed - re	s. without injury. Res.			
	•	se of call light for			
	assistance."	3			
	"07-27-13 5:00	a.m. Heard res.			
	calling out. En				
		und res. sitting on			
	• •	n] floor in front of			
	_	nied following, denies			
	· ·	G.			
	pain. No injuri	CO.			
	 "00_07_12 7:25	p.m. Writer heard			
		r 'help.' Writer et			
	1	ered resident room et			
	[and] observed res. on shower floor on her right hip. Resident would not allow writer or CNA to assist from				
		sked if res. could			
	1	leg, res. said 'no.'			
		es. 'how did you fall ?'			
	Res. said 'I wa	s reaching for			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		02/06/2014		
		ı		ADDRESS, CITY, STATE, ZIP CODE	1		
NAME OF P	PROVIDER OR SUPPLIER	₹					
BEDRON	IRE OF CASTLETO	N	8480 CRAIG ST INDIANAPOLIS, IN 46250				
DERNOIT	INE OF CASTLETO	3N	INDIAI	NAF OLIS, IN 40250	_		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	something.' Re	es. said 'I'm hurting.'"					
		•					
	Further review	of the					
		y notes indicated the					
		ansferred to the local					
	•	or evaluation and					
	treatment and						
	admitted with a	fractured hip. After					
	the resident's h	nospitalization, the					
	resident was tr	ansferred to a skilled					
		for rehabilitation					
	services.	101 Teriabilitation					
	Services.						
		facility Incident					
	Report on 02-0	3-14 at 11:00 a.m.,					
	and dated 09-0)7-13 at 7:35 p.m.,					
	indicated the in	cident occurred on					
	Saturday in the	e resident "bathroom,					
	•	Nature of Incident:					
		ed. Severity Code					
		-					
		with admission to					
	hospital."						
	A review of the	facility "Risk					
	Identification E	valuation, dated					
		the resident's fall					
	·	cated the resident					
		ne past 12 months,					
		•					
	•	racture [09-07-13], a					
		glaucoma, with					
		red that may cause					
	the resident to	fall - Myasthenia					
	Gravis [severe]	and left					
	hemiparesis."	-					
			1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMF 02/06	E SURVEY LETED 6/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8480 CRAIG ST INDIANAPOLIS, IN 46250					
BERKSH (X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR PEGULATORY OR During an inter 12:15 p.m. the "The screw car chair - that's he broke my hip. hollered until some." When int was with her in she was in the indicated, "No myself but I ho them to hear medicated or many or myself but I how them to hear medicated or many or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear medicated or myself but I how them to hear myself but I how the hear myself but I how them to hear myself but I how the hear myself but I how the hear myself but I how	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) view on 02-03-14 at resident indicated me out of the shower ow I fell - that's when I I laid on the floor and omeone came to help erviewed if anyone the bathroom, while shower the resident I was in there by llered real loud for ie."			SHOULD BE	(X5) COMPLETION DATE		
	unattended in to the current "12-07-13 indicate to perform showering task assistance as r	is with physical needed: washing er body," and not the vision while						
	02-03-14 at 4:3 Administrator in originally reside as her disease	ndicated the resident ed in the Manor, but progressed, and care, was moved to it.						

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